

TRANSOBTURATOR MALE SLING – REPOSITIONING TEST AND SURGICAL TECHNIQUE

Introduction

Male transobturator sling to correct postprostatectomy stress urinary incontinence, acts by repositioning the urethral sphincter complex back into the pelvis. Optimal placement of the sling on the urethral bulb is ensured by following a recommended surgical technique. The repositioning test maneuver is performed before the procedure to check the sphincter residual activity.

Design

This video begins demonstrating the repositioning test. In this maneuver we ask to the patient to perform a pelvic contraction while the surgeon makes a soft pression in the perineum in the level of bulbous urethra. Throughout direct endoscopic view it was possible to demonstrate a good coaptation in the external sphincter zone and confirm a good residual sphincter function. After that maneuver the surgical procedure was initiated by a midline perineal incision approximately 5 cm in length and the dissection carried through the subcutaneous tissue using electrocautery down to the bulbospongiosus (BS) muscle. The BS muscle is opened in the midline to expose the corpus spongiosum (CS), which is mobilised distally, laterally, and inferiorly. The central tendon is sectioned. This procedure was performed carefully to increase the mobility of the urethra. An incision is then made approximately 1–2 cm below the adductor longus tendon and lateral to the ischiopubic ramus. To confirm the right position a percutaneous spinal needle may be used to identify the local of insertion. A small incision in the skin is made to facilitate needle entry. The helical needle is held at a 45° angle to the midline incision. A finger is placed in the puncture below the ischiopubic ramus to protect the urethra and guide needle placement. The needle is then driven straight in through the puncture. The needle should be pushed deep enough to go into the obturator foramen. Any resistance to the needle suggests contact with the ischial bone and indicates the needle is too superficial and should be pushed deeper. The needle is palpable on the physician's finger. Before bringing the needle through the fascia, the physician's hand drops toward the midline and brings the needle out as high as possible in the triangle between the ischiopubic ramus and the urethra. The mesh is secured to the needle via the connector and then rotated back through the incision. This needle pass is repeated on the opposite side. The central portion of the mesh is fixed to the CS to avoid migration of the sling. After suture fixation, the sling is tensioned by pulling on both arms of the sling, which generates 2–4 cm of proximal movement of the urethra and CS. The mesh can be optionally tunneled back to the midline incision to reduce the risk of sling migration. The BS muscle is closed as well as the subcutaneous tissues, and a 14F Foley catheter is left in place for one day. A compression pack may be positioned on the perineum to reduce the risk of haematoma.

Results

In this video it was possible to demonstrate the repositioning test, the coaptive zone in the external sphincter zone and the surgical technique of male transobturator sling to correct postprostatectomy stress urinary incontinence.

Conclusion

According to the literature the repositioning test seems to be one important criterion for surgical success and it was present in this patient. The transobturator sling acts by repositioning the urethral sphincter complex back into the pelvis and is an option in the postprostatectomy stress urinary incontinence treatment.

Disclosures

Funding: Dynamesh **Clinical Trial:** No **Subjects:** HUMAN **Ethics Committee:** University of Campinas **Helsinki:** Yes **Informed Consent:** Yes